STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315413	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peace Care St Ann's	198 Old Bergen Road Jersey City, NJ 07305

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490 Based on observation, interview, record review and policy review, the facility failed to ensure dignity was provided to one (Resident (R)165) out of one resident regarding grooming, in that nursing staff failed to remove excessive facial hair on a female resident's chin. This deficient practice could compromise the resident's dignity and comfort. Findings include: Review of the facility's undated policy titled, Activities of Daily Living (ADLs)revealed, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate .care and services will be provided for the following activities of daily living: 1.grooming . Review of R165's Face Sheet located in the Electronic Medical Records (EMR) under the Profile tab revealed R165 was admitted to the facility on [DATE]. Review of R165's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/04/24, located in the EMR under the MDS tab indicated the facility assessed R165 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R165 was cognitively alert. Review of R165's Care Plan dated 10/04/24, located in the EMR under the Care Plan tab, revealed, R165 exhibits new onset of decreased balance, strength, and activity tolerance impacting independence with ADL . Review of the ADL Care Schedule provided by the facility revealed R165 was scheduled for ADL care on Tuesdays and Fridays. Observation on 10/15/24 at 11:37 AM, R165 had 20 to 24 half-inch white hair on her chin. Interview at this time, when asked about the excessive facial hair, R165 stated, I would like them to be removed, they bother me. Interview on 10/16/24 at 11:05 AM, Certified Nurse Aide (CNA)2 confirmed facial hair is a task that the CNAs address during ADL care. Observation on 10/17/24 at 10:01 AM, R165's facial hair remained on her chin. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/17/24 at 10:10 AM, R165 stated that during her entire stay at the facility, no one has addressed the facial hair on her chin. The resident further stated, I have a beard. Registered Nurse (RN)2 stated at this time that when CNAs provide ADL care, they should have noticed and addressed the facial hair. RN2 stated it is the expectation of the facility that ADL care includes removing facial hair. NJAC 8:39-4.1 (a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to accurately code the Minimum Data Set (MDS) for one (Residents (R) R62) of two residents reviewed for anticoagulant medications. Inaccuracy of the MDS could lead to problems in the care area not being addressed appropriately in the care plan. Findings include: Review of the RAI manual, dated 10/24 located at https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf revealed N0415: High-Risk Drug Classes: Use and Indication, Coding Instructions .Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days). Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class .Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant. Review of R62's quarterly MDS with an ARD date of 08/13/24, located in the MDS tab of the EMR revealed an admitted [DATE].revealed a diagnosis of unspecified atrial fibrillation. The MDS was not checked for Anticoagulant medication. Review of R62's physician orders, dated 04/04/24, located in the EMR under the Order tab revealed Rivaroxaban Oral Tablet 15 MG [milligrams] (Rivaroxaban) Give 1 tablet by mouth in the evening for Afib [atrial fibrillation]. Review of R62's Medication Administration Record (MAR) dated 10/24, located in the EMR under the Order tab reveal a current order for Rivaroxaban Oral Tablet 15 MG (Rivaroxaban) Give 1 tablet by mouth in the evening for Afib -Start Date- 04/04/24. During an interview on 10/17/24 at 10:56 AM, the MDSC was asked about R62's MDS with an ARD of 08/13/24 section N. The MDSC stated nursing [unit manager] on each floor completed the medication section (Section N) in the MDS. The MDSC was asked if anticoagulant should be checked on the MDS if prescribed. The MDSC stated, Yes, anticoagulants should be coded on the MDS. During an interview on 10/17/24 at 11:13 AM, RN1 checked the EMR and confirmed that R62 was currently prescribed an anticoagulant and that she should have coded R62's MDS for anticoagulant. During an interview on 10/17/24 at 3:02 PM, the Director of Nursing (DON) was asked what her expectation was for the accurate coding of the MDS for anticoagulants. The DON stated, If there is an order for an anticoagulant it should be coded on the MDS. The DON stated the unit manager on each floor was responsible for checking the accuracy of her entries on the MDS. NJAC 8:39-33.2(d)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490 36190 Based on observation, interview, record review and policy review, the facility failed to maintain acceptable nutritional parameters by not monitoring weights for accuracy, assessing weight changes, implementing interventions, monitoring meal intake, and/or providing meal assistance for two (Residents (R)49 and R52) of three residents reviewed for nutrition in the sample of 42 residents. This had the potential to cause further weight loss without a root cause analysis and/or additional interventions put in place. Findings include: Review of the facility's policy titled Clinical Nutrition Services, dated 10/24, provided by the facility revealed, The dietitian/qualified nutrition professional identifies residents who are at risk and/or potential risk for nutrition-related problems. The dietitian/qualified nutrition professional recommends interventions to maintain the resident's nutrition status, based on resident preference and tolerance .For residents at nutritional risk: Determine appropriate interventions based on the identified etiology/cause of the risk factor and resident preferences. Review of the facility's policy titled Standards of Care, dated 08/20, provided by the facility revealed, The Registered Dietitian (RD) or designee are responsible for monitoring and noting miscellaneous changes or other pertinent nutrition information in an interim dietary progress note of the medical record .Review resident weights and identify significant weight changes (gains and losses) as well as those with noted trends; > [greater than or equal to]5% change in one month, >7.1% (percent) in three months, >10% in six months. Complete an assessment of the weight change and document findings on a nutrition progress note or a facility utilized assessment weight change form The Registered Dietitian completes documentation, at minimum monthly, on a nutrition progress note for residents deemed at high nutritional risk form .Nutritional consults are to be addressed in a timely manner with a goal of 24 to 72 hours upon receiving by the Registered Dietitian or designee. 1. Review of R49's Face Sheet, located in the Electronic Medical Record (EMR) under the profile tab revealed the resident was admitted on [DATE] with a diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, and anemia. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R49's Dietician Note dated 09/18/24 located in the EMR under the progress note tab revealed, R49's was classified as Malnourished, Resident has a -29.6% weight loss from July-September. Resident weight over the past two months has been of a significant decline. Resident was 164 pounds (lbs.) in June, and now it is 120.6 lbs. The resident continues to lose weight due to poor PO [by mouth] intake. The resident is documented with poor- no intake. Resident has few spoonful at mealtimes at most. The resident is encouraged by staff to increase intake without success. Goals/interventions: RD will continue to monitor R49's appetite, intake of food and fluids, and weight and make her comfortable. RD will honor any resident's food requests . Continue review of the RD notes dated, 08/20/24 revealed, significant weight loss; note dated 07/18/24 revealed, significant weight loss; and note dated 06/06/24 revealed a diet order change to Carbohydrate Controlled Diet (CCD), Heart healthy diet, pureed texture, nectar thick consistency. Review of R49's weights, located in the EMR under the Weights and Vital tab revealed the following: 01/08/24-157 pounds (lbs.) 02/14/24-171.8 lbs. 03/22/24-171.4 lbs. 04/17/24-175.7 lbs. 05/06/24-175.7 lbs. 06/04/24-170.2 lbs. 07/10/24-137.0 lbs. 08/08/24-123.8 lbs. 09/10/24-120.6 lbs. 10/08/24-108.6 lbs. Review of R49's EMR Progress notes under the Progress notes tab revealed the following amount of food consumption at the meals: On 10/15/24 consumed 100% with assistance; on 10/14/24 Dinner consumed 25% despite encouragement and assistance from staff, Resident ate 100% breakfast and lunch poorly; on 10/13/24, Dinner consumed 50% with assistance from staff, 10/13/24, Resident had poor (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appetite during shift; on 10/12/24, Dinner consumed 50% with assistance from staff; on 10/10/24 Resident ate 100% for both meals; on 10/04/24 Good appetite for dinner; on 10/01/24 Good appetite with dinner, consumed 75% puree meal with assistance from staff; on 09/30/24 Poor appetite with dinner, consumed two spoons of puree meal despite encouragement and assistance from staff; on 09/29/24, Breakfast and Lunch consumed 90% and drank some liquid with assistance from staff; on 09/27/24 Dinner consumed 50% and drank 4 ounces liquid with assistance from staff; on 09/27/24 Appetite good for both meals; on 09/26/24 Dinner consumed 50% and drank 4 ounces liquid with assistance from staff; on 09/23/24 Poor appetite with dinner, consumed 25% spoon-fed of puree food despite encouragement and assistance from staff. Drank 4 ounces fluids; on 09/22/24 Noted remains poor appetite with dinner, consumed 3 spoons-fed of puree food despite encouragement and assistance from staff. Drank adequate fluids; on 09/21/24 Poor appetite with dinner, consumed 25% despite encouragement and assistance from staff. Review of R49's Doctors Orders located in the EMR under the orders tab revealed no orders for nutritional supplements or medication to encourage appetite. Review of R49's Care Plan found in the EMR under the Care Plan tab last updated on 09/23/24, did not reveal any issues or concerns about R49's weight loss, nor a plan to see if the resident's weight was correct, and no indication of any nutritional supplements to be added. Interview on 10/16/24 at 3:30 PM, the RD stated that once a resident has reached 5% of weight loss, interventions are put in place. The RD stated, I should have been monitoring the resident more closely. Interview on 10/17/24 at 9:20 AM, Registered Nurse (RN3) revealed the facility's protocol for residents who have lost significant weight is to contact the RD, who will check weights, determine the reason for the weight loss, change the resident's diet, and refer to the physician to add supplements. Interview on 10/17/24 at 11:27AM, the Nurse Practitioner (NP) stated that when there was significant weight loss, several interventions can be put in place such as supplements, swallowing evaluations, and medications to encourage appetite. The NP confirmed none of the interventions mentioned were put in place for R49. Interview on 10/17/24 at 10/17/24 at 11:27AM, the Director of Nursing (DON) revealed that R49's weight loss was not handled properly by the facility. Even though this resident has gone under Hospice care in June 2024, significant weight loss not due to the resident's diagnosis should have been investigated and the proper interventions put in place to reduce any further weight loss. 2. Review of R52's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 07/09/24, located in the MDS tab of the EMR revealed an admitted [DATE] and a Brief Interview of Mental Status (BIMS) score of two out of 15, indicating R52's cognition was severely impaired. The MDS indicated diagnoses of diabetes mellitus, dementia, malnutrition, heart failure, and adult failure to thrive. Review of R52's diet order dated 09/01/23, located in the EMR under the Order tab revealed Heart Healthy, NAS [no added salt] diet, Regular texture, Thin Liquids consistency. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R52's Nutritional Recommendation, dated 01/23/24, located in the hard chart under the Dietary tab revealed Weekly Weights due to weight loss. Review of R52's Care Plan, dated 04/11/24, located in the EMR under the Care Plan tab revealed R52 is at risk for malnutrition in the setting of hx. [history] significant weight loss, moderate protein-calorie malnutrition, and admitting dx [diagnosis] of Adult Failure to Thrive. The goal included, R52 will have gradual weight gain toward BMI [body mass index] > [greater than] 24.5 through review date. An intervention included, Weight monitoring (FREQ) [frequently]. Review of R52's Mini Nutritional Assessment, dated 07/11/24, located in the EMR under the Assessment tab, revealed R52 had BMI of 21 to less than 23 and was at risk of malnutrition with a score of 11. Review of R52's quarterly Nutritional assessment dated [DATE] located in the EMR under the Progress Note tab revealed height at 69.0 inches and weight at 154.9 pounds, at risk of malnutrition, and Resident BMI is below 23, and resident has PMH [past medical history] of dementia which puts resident at risk for malnutrition. Review of R52's order, dated 09/07/24, located in the EMR under the Order tab revealed Lasix Oral Tablet 40 MG (Furosemide)(diuretic medications) Give 1 tablet by mouth one time a day for Edema Hold for SBP [Systolic Blood Pressure] less than 100mmhg [millimeters of mercury]. Review of R52's Physician Progress Notes in the EMR under the Progress Notes tab dated 08/17/24, 09/14/24, and 10/12/24 revealed, Rt [right] arm edema . Review of R52's weight history, located in the EMR under the Weight tab, revealed R52 had lost 10 % of his body weight in 18 days, from 09/20/24 to 10/08/24 and weights were not consistently obtained: On 10/08/24 at 139.9 Lbs. Mechanical Lift, reweigh 10/16/24 at 154.5 Lbs. On 09/20/24 at 155.8 Lbs. Wheelchair On 09/11/24 at 155.8 Lbs. Wheelchair On 08/12/24 at 155.0 Lbs. Wheelchair On 07/09/24 at 154.9 Lbs. Wheelchair On 06/14/24 at 153.5 Lbs. Wheelchair On 05/03/24 at 154.0 Lbs. Wheelchair On 04/16/24 at 148.4 Lbs. Mechanical Lift (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R52's Nutrition/Dietary Note, dated 10/18/24, located in the EMR, under the Progress Note tab revealed Possible sig.[significant] weight change. RD requested new weight to verify weight change- RD has observed resident in dining room previously with good PO [oral] intake. Pending weight change will follow up and make dietary changes PRN [as needed]. On 10/16/24 at 9:36 AM, R52 was served his breakfast in bed and feeding himself. R52's breakfast included scrambled eggs, juice, fruit, a muffin, and coffee. On 10/16/24 at 9:47 AM, certified nurse aide (CNA)1 was observed bringing R52's breakfast tray out of his room. CNA1 confirmed R52 ate 100% and nothing extra was provided. On 10/16/24 at 12:52 PM, R52 was served lunch in bed and feeding himself. His lunch included a muffin, coffee, green beans, smothered chicken, corn bread dressing, and a beverage. On 10/16/24 at 12:59 PM, R52 was observed in bed with covers over his head and his lunch tray pushed off to the side with a napkin on top of the plate. Only half of R52's meal was consumed. Staff did not offer more food or an alternative. On 10/16/24 at 1:09 PM, R52 was again observed in bed with covers over his head and his lunch tray pushed off to the side with a napkin on top of the plate. Only half of R52's meal was consumed. Staff did not offer more food or an alternative. During an interview on 10/16/24 at 1:50 PM, the RD was asked if she was aware of R52's recent weight loss of 10% in 18 days. The RD stated, Yes, she reviewed R52's weights on 10/14/24 and requested a reweigh for the 139.9-pound weight because it was off from his normal weight history. The RD confirmed R52 had a history of weight loss. The RD stated R52's weight was back to normal and he had a good intake. The RD was asked why she only documented R52's nutritional status and requested a reweigh today, 10/16/24, eight days later. The RD stated she wasn't sure. The RD was asked should a sudden weight loss be caught sooner. The RD stated she was trying to figure it out. RD was asked about R52 only eating 50% at lunch today, 10/16/24 and was R52 receiving a supplement or getting extra calories when he doesn't eat well. The RD stated, No, because he typically eats very well. The RD was asked if she was aware R52 had a recommendation on the hard chart for weekly weights in 01/24 and a nutritional supplement on 07/23. The RD stated she wasn't aware. The RD stated during the facility's morning meetings, they will discuss weight changes or poor intake. The RD was asked if R52 was discussed and the RD stated, No. The RD was asked why R52's weight was sometimes obtained by a mechanical lift and other times in a wheelchair. The RD stated she wasn't sure and wasn't aware of the requirement to be consistent with obtaining the weights. The RD was asked if R52's physician was aware of R52's significant weight loss when the weight was obtained on 10/08/14. The RD stated she wasn't sure, but she placed a paper in the hard chart to flag the physician next time they were in the building to see the resident. The RD confirmed she doesn't make a telephone call to the physician about weights. During a telephone interview on 10/17/24 at 9:47 AM, Primary Care Physician (PCP)1 was asked if R52 was her patient. PCP1 stated, Yes. PCP1 was asked if she was informed of R52's weight change of 155.8 pounds on 09/20/24 to 139.9 pounds on 10/08/24. PCP1 stated she had not been informed. PCP1 was asked how the facility informed her of weight changes. PCP1 stated they leave a paper on the front of the chart, but R52 did have a lot going on medically such as edema and fluid retention. PCP1 went on to say the facility does call her for something dramatic. PCP1 was asked if R52's weight change was dramatic and PCP1 stated, Yes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 1:37 PM, the DON was asked if she was aware of R52's weight of 139.9 pounds on 10/08/24. The DON stated, No. The DON went on to say on the 10th of every month, all weights should be completed and then the weights are reviewed. The DON stated the certified nurse aides weighed the residents and gave the weights to the nurses to enter into the EMR. The DON stated if a reweigh was needed because of a big difference from last weight, reweighs should be right away. The DON was asked if R52's 10/08/24 weight of 139.9 pounds was discussed in the morning meetings. The DON stated, No. The DON was asked when were reweighs completed. The DON said, right away.' The DON was asked when the physician should be notified of significant weight loss. The DON stated, The same day. DON was asked why R52's weights were obtained using different methods and was she was aware of the requirement of using the same process/method for obtaining weights. DON stated, Yes, but wasn't sure why it was inconsistent. The DON was asked what her expectation was for addressing weight loss. The DON stated to notify the physician of weight loss that day. The DON confirmed the facility did not have a policy addressing weight accuracy or consistency. Review of the facility's policy Clinical Nutrition Services, revised on 10/24 revealed, The dietitian/qualified nutrition professional identifies residents who are at risk and/or potential risk for nutrition-related problems. The dietitian qualified nutrition professional should recommend interventions to maintain the resident's nutrition status, based on resident preference and tolerance . Review of the RD's responsibilities (job description) provided by the facility revealed, .for residents identified as malnutrition, the RD will log results into the MNA tracker to establish nutrition follow-up and recommendations, will meet weekly with the disciplinary team, discuss nutrition concerns with the IDPT [Interdisciplinary Plan of Treatment], update the care plan to reflect the appropriate interventions put in place . NJAC 8:39-17.1(c) NJAC 8:39-17.2(d) NJAC 8:39-27.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on observation, interviews, record review, review of facility policies, and Centers for Disease Control (CDC) and Prevention guidance, the facility failed to clean and disinfect patient equipment after use for two of five residents (Resident (R) 16 and 54) reviewed for infection control and failed to follow hand hygiene practices during medication pass for one of five residents (R7) reviewed for medication administration. These failures could promote the spread of multi drug resistant organisms (MDROs) throughout the facility. Findings include: 1. Review of R16's undated Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE]. The Admission Record revealed diagnoses of atrial fibrillation and hypertension. Review of R16's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/05/24, located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R16 was cognitively intact. During an observation in R16's room on 10/16/24 at 8:20 AM, revealed Licensed Practical Nurse (LPN) 1 performed hand hygiene, picked up a clean wrist blood pressure cuff from the clean paper towel on top of the medication cart, and took R16's vital signs. She performed hand hygiene again after obtaining vitals. LPN1 placed the dirty blood pressure cuff down on top of the clean paper towel on top of the medication cart. 2. Review of R54's undated Admission Record in the Profile tab of the EMR revealed an initial admitted [DATE]. The Admission Record revealed diagnoses of type two diabetes mellitus and hypertensive heart disease with heart failure. Review of R54's quarterly MDS with an ARD of 07/02/24, located in the EMR MDS tab, revealed a BIMS score of 15 out of 15 which indicated R54 was cognitively intact. During an observation in R54's room on 10/16/24 at 8:35 AM, revealed LPN1 performed hand hygiene, picked up the dirty blood pressure cuff from the paper towel on top of the medication cart, and took R54's vital signs. She performed hand hygiene after obtaining vitals. She set the dirty blood pressure cuff down on top of existing paper towel on top of the medication cart. During an interview on 10/16/24 at 8:46 AM, LPN1 stated, I clean the blood pressure cuff after two or three uses. It should be done between and after with bleach wipes. During an interview on 10/16/24 at 8:50 AM, the Director of Nursing (DON) stated, The nursing staff all know that they clean patient care equipment before and after each use and in between. They are to use bleach wipes and let the equipment air dry for three minutes. They have wrist blood pressure cuffs, and they can alternate and use one while the other one is drying. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 9:10 AM, Infection Preventionist (IP) stated, Staff are supposed to use the bleach wipes in the purple top containers and let air dry for two minutes after cleaning. Staff are trained to clean and disinfect all patient care equipment after they use it or touch a resident with it. Review of the facility's policy titled, Infection Prevention and Control - Cleaning of Non-Critical Equipment revised in 01/2018, indicated, under the Purpose section, To establish prevention and control procedures and policies based on recognized guidelines in the cleaning of Non-Critical Equipment . Resident care devices as identified in this section are: .blood pressure cuffs . The definition as stated in the tag is: non-critical items are defined as those that come in contact with intact skin or do not contact the resident. The Policy section indicated, All non-critical items are to be cleaned with a low-level disinfection by cleaning periodically and after visible soiling with an EPA disinfectant detergent or germicide that is approved for healthcare settings.Use EPA approved Germicidal Disposable Wipes (purple top PDI-Super Sani Cloth or equivalent) .thoroughly wet surface and objects. Treated surfaces and objects must remain visibly wet for a full two (2) minutes. Let dry. All non-critical equipment are to be thoroughly cleaned and disinfected with an EPA approved disinfectant between residents. Items that are contaminated with C-Diff spores are to be cleaned with a 1:10 ratio dilution of sodium hypochlorite (nine parts water to one part bleach). 3. Review of R7's undated Admission Record in the Profile tab of the EMR revealed an initial admitted [DATE]. The Admission Record revealed a diagnosis of chronic systolic congestive heart failure. Review of R7's quarterly MDS with an ARD of 09/30/24, located in the EMR MDS tab, revealed a BIMS score of 12 out of 15 which indicated R7 was moderately cognitively impaired. During an observation in R7's room on 10/16/24 at 8:30 AM, LPN1 performed hand hygiene, and gave R7's the cup of her morning medications. R7 took the cup of medications, touched LPN1's fingers and gave LPN1 the medicine cup back. LPN1 gave R7 a cup of water. R7 drank the water and gave the empty water cup back to LPN1. She did not perform hand hygiene. She continued to move onto the next resident preparing her medications. During an interview on 10/16/24 at 8:46 AM, LPN1 stated, I usually clean my hands after every resident. During an interview on 10/16/24 at 8:50 AM, the DON stated, All the staff know to perform hand hygiene in between each resident or when visibility soiled. Review of the facility's policy titled, Infection Prevention and Control - Hand Hygiene revised in 02/2018, indicated, Purpose, Effective hand hygiene removes transient microorganisms, dirt and organic material from the hands and decrease the risk of cross contamination from residents . The Policy section indicated, All members of the healthcare team will comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines. Review of the CDC website and Prevention website https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, titled, Clinical Safety: Hand Hygiene for Healthcare Workers updated 02/27/24 revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315413	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peace Care St Ann's	198 Old Bergen Road Jersey City, NJ 07305

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Know When to Clean Your Hands: Immediately before touching a patient .After touching a patient or patient's surroundings .When to use an alcohol-based hand sanitizer (ABHS): Unless hands are visibly soiled, ABHS is preferred over soap and water in most clinical situations . NJAC 8:39-19.4 (a)(b)(c)(i)(n)